

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05175

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Neeritt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Neeritt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>Sutton</u>	(First) <u>T.</u> (Middle) <u>Ball</u> (Last)	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>27</u> (Year) <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 31 1866</u>
9. AGE last birthday <u>84 yrs.</u>		If under 1 year: Months <u>84</u> Days <u>27</u> Hours <u>19</u> Min. <u>37</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman, Cysterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Commercial</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>D. Dawson Ball</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Hunt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Sutton T. Ball, Neeritt Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

##### Immediate cause

(a) Coronary thrombosis

##### Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive cardio-vascular disease

(c)

INTERVAL BETWEEN ONSET AND DEATH

6 days

year +

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION

#### 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec, 1949, to May 26, 1951, that I last saw the deceased alive on May 26, 1951, and that death occurred at 6:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 29, 1957</u>	<u>Neeritt cemetery</u>	<u>Neeritt Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>May 28/51</u>	<u>Mrs. Robert L. Seth</u>	<u>Newnam &amp; Harrison</u>	<u>St. Michaels</u>	

91026 md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 22 1961  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05176

## CERTIFICATE OF DEATH

Reg. Dist. No. 29.0

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>124 Goldsboro Street</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JEANETTE</u>	(Middle)	(Last) <u>BATES</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Oct 9, 1902</u>
9. AGE last birthday <u>50</u> yrs.		10. DATE OF DEATH <u>May 7, 1951</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proof Reader</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Fredericksburg</u>	
12. FATHER'S NAME <u>Mr. Henry S. Weber</u>		13. MOTHER'S MAIDEN NAME <u>Miss Mary Morris</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>111-22-6235</u>	
16. INFORMANT AND ADDRESS <u>Miss Natalie Bates</u>		17. ADDRESS <u>111-22-6235</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>Cerebral Hemorrhage</u>		<u>5 1/2 hrs</u>
(b) Antecedent cause(s) <u>Hypertension</u>		<u>2 + yrs</u>
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to May 7, 1951, that I last saw the deceased alive on May 7, 1951, and that death occurred at 4:30 P. m., from the causes and on the date stated above.

SIGNATURE M. V. Palmer ADDRESS M. D. Easton, Md DATE SIGNED 5/17/51

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>West Lawn</u>	LOCATION (City, town, or county) <u>Easton, Md</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>5/8/51</u>	REGISTRAR'S SIGNATURE <u>N. A. Neerius</u>	21. FUNERAL DIRECTOR <u>Wm. E. Newman &amp; Co</u> ADDRESS <u>Easton</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

390 459

RECEIVED

RECEIVED

RECEIVED  
MAY 22 1961  
BUREAU A. A.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Harlock</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Mr. Ernest</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov 26, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>67</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr Edmund Beel</u>		14. MOTHER'S MAIDEN NAME <u>Martha Wheatley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. Francis Beel (Same)</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Thrombosis Left Hemisphere

## Antecedent cause(s)

(b) Generalized Arteriosclerosis(c) stating the underlying cause last

INTERVAL BETWEEN ONSET AND DEATH

8 days10 yrs11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7/26, 1943, to 5/29, 1951, that I last saw the deceasedalive on 5/28, 1951, and that death occurred at 1:00 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REPOSEAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>June 1st 1951</u>	<u>Harlock</u>	<u>Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5/30/51</u>	<u>M. D. Neer</u>	<u>S. B. Wilboughby</u>	<u>Harlock 290636</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 7 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05178 290

1. PLACE OF DEATH- COUNTY <u>TALBOT</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>TALBOT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE (Rural)</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>ALLIE</u> (First) <u>BLADES</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>12</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWER</u>	8. DATE OF BIRTH <u>JUNE 19, 1863</u>
9. AGE last birthday <u>87</u> yrs. <u>10</u> Months <u>24</u> Days		10. If under 1 year If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED TENANT FARMER</u>	
11. BIRTHPLACE (State or foreign country) <u>Dorchester Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John BLADES</u>		14. MOTHER'S MAIDEN NAME <u>SARAH SATTERFIELD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>ROLAND BLADES HORLOCK</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Valvular heart disease</u>			<u>4 yrs.</u>
Antecedent cause(s) (b) <u>Arterio sclerosis general</u>			<u>15 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 2<sup>nd</sup></u> , 19 <u>51</u> , to <u>May 12<sup>th</sup></u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 9<sup>th</sup></u> , 19 <u>51</u> , and that death occurred at <u>4 A.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>William S. Seymour M.D.</u>		ADDRESS <u>Trappe Md.</u>	
DATE SIGNED <u>5/28/51</u>			
23. BURIAL-CREMATATION REMOVAL (Specify) <u>DECEASED</u>		DATE THEREOF <u>5/15/1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Windy Hill</u>		LOCATION (City, town, or county) <u>TRAPPE Md.</u>	
DATE REC'D BY LOCAL REG. <u>5/13/51</u>		REGISTRAR'S SIGNATURE <u>N. H. Neirius</u>	
24. FUNERAL DIRECTOR <u>MORRICE E. NEWNAM &amp; Son</u>		ADDRESS <u>EASTON, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15-1



RECEIVED  
JUN 4 1961  
BUREAU Y. S.



MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

05179

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Car.</u>	
CITY (If outside corporate limits, write RURAL and give nearest TOWN) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton, Memorial</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr John Wesley Carlisle</u>		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>16</u> (Year) <u>51</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2/4/1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Carlisle</u>		14. MOTHER'S MAIDEN NAME <u>Mary Donovan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Virgil Moore &amp; Son, Denton Md</u>			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion</u>			<u>1 1/2 hr</u> <u>Years</u>
Antecedent cause(s) (b) <u>Irreducible scrotal hernia</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>none</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> <u>1:20 AM</u>			
SIGNATURE <u>Louis White MD</u>		DATE SIGNED <u>5-16-51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>buried</u>		NAME OF CEMETERY OR CREMATORY <u>Denton</u>	
DATE REC'D BY LOCAL REG <u>5/17/51</u>		24. FUNERAL DIRECTOR <u>Virgil Moore</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

820105

RECEIVED  
MAY 23 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05180

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>R.F.R. # 4</u>	
3. NAME OF DECEASED (First) <u>Barbara</u> (Middle) <u>May</u> (Last) <u>Carmine</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>2/9/19</u>
9. AGE last birthday <u>32</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. Milton J. Sving</u>		14. MOTHER'S MAIDEN NAME <u>Orthy M. Sving</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Ms. Malcolm Carmine</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Sarcoma of Liver

Antecedent cause(s)

(b) None

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

Sarcoma of Liver

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at m. Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 25, 1951, to May 11, 1951, that I last saw the deceasedalive on May 11, 1951, and that death occurred at 11:20 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Arthur B. Gilman, M.D. Easton Md May 14

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

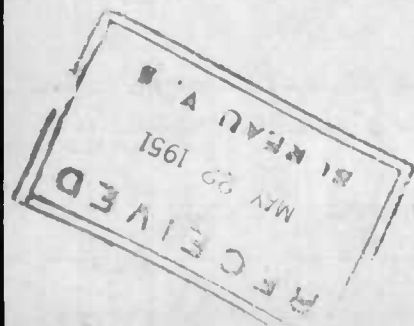
ADDRESS

5/12/57N.H. NeerustWm. E. ThomasEaston Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



Item 9 on:

FAM No. G 1 MAY 24 1957 MICHIGAN STATE DEPARTMENT OF HEALTH

05181

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Droppe</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Droppe</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Droppe R.F.D.</u>		STREET ADDRESS <u>Droppe R.F.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Isaac H Copper</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Sept 21 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Easton Md</u>
13. FATHER'S NAME <u>Peter Copper</u>		14. MOTHER'S MAIDEN NAME <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Sadie Brooks</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Acute parenchymatous nephritis

## Antecedent cause(s)

(b)

Chronic Myocarditis

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

3 yrs3-4 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 6, 1946, to May 10, 1951, that I last saw the deceasedalive on May 10, 1951, and that death occurred at 2 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Waymond T. Webb, M.D.Easton, Md

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 5/15/51

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

W. N. Newlin2411 N. Charles St. H. BayneCambridge820105

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

05182

1. PLACE OF DEATH- COUNTY <i>Tachot Co</i>		EASTON MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i>		COUNTY <i>Tachot</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Md</i>		LENGTH OF STAY (in this place) <i>12 hrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Easton, Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Easton Memorial Hospital</i>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <i>Mary</i>	(Middle)	(Last) <i>Dobson</i>	4. DATE OF DEATH (Month) (Day) (Year) <i>May 27 1951</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Jun 22 1873</i>	9. AGE last birthday <i>78</i> yrs.	If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Chase</i>		14. MOTHER'S MAIDEN NAME <i>Louise Chase</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT AND ADDRESS <i>Hilda Dobson</i>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) *Gastric Cancer of Abdomen*

INTERVAL BETWEEN ONSET AND DEATH

*4 mos*

## Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

*Gravid Nephrosclerosis hypertension*

18. AUTOPSY?

Yes ☐ No ☐

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to *5-27*....., 19*51*....., that I last saw the deceasedalive on *5-27*....., 19*51*....., and that death occurred at *9:30*.....m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

*Dr. F. B. Buel**MD**Easton**MD**5-27-51*

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

*5/28/51**N. H. Neuman**Easton Md**Easton Md*

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
JUN 4 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05183  
Reg. Dist. No. 2.90

1. PLACE OF DEATH: COUNTY <u>Talbot Co</u> <u>Easton</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> TOWN <u>Easton</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Mr. George</u> (First) <u>Elmer</u> (Middle) <u>Julin</u> (Last)		4. DATE OF DEATH <u>May 5</u> (Month) <u>5</u> (Day) <u>1951</u> (Year)	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>w</u>	8. DATE OF BIRTH <u>Nov 1, 1884</u>
9. AGE last birthday <u>66</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Ind</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. MOTHER'S NAME <u>Mr. Thomas Henry Julin</u>	
14. MOTHER'S MAIDEN NAME <u>Miss Ellen Lott</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Mrs. Besse Rice</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>Cerebral Vascular Accident</u>		<u>1 day.</u>	
Antecedent cause(s) <u>Arteriosclerosis</u>		<u>? yrs.</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Acute Congestive Heart Failure</u>		<u>1 day.</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary Fibrosis and Emphysema</u>		<u>33 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/4</u> , 19 <u>51</u> , to <u>5/5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5/5</u> , 19 <u>51</u> , and that death occurred at <u>11:00</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Shepard Keen Jr. M.D.</u>		ADDRESS <u>Easton</u>	
DATE SIGNED <u>5/6/51</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>May 8, 1951</u>	
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		LOCATION (City, town, or county) <u>Easton</u>	
DATE REC'D BY LOCAL REG. <u>5/6/51</u>		REGISTRAR'S SIGNATURE <u>M. H. Newnes</u>	
24. FUNERAL DIRECTOR <u>Maurice E. Newnes &amp; Son</u>		ADDRESS <u>md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05184

Reg. Dist. No. 291

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels.</u> TOWN <u>St. Michaels.</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place) <u>Life</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u> TOWN <u>St. Michaels</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) <u>Ella</u> (Middle) <u>Jewell</u> (Last) <u>Hairbank</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>25</u> (Year) <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 15 1870</u>	9. AGE last birthday <u>81</u> yrs.	If under 1 year Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Denton Maryland</u>	
13. FATHER'S NAME <u>John Jewell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Cunningham</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT AND ADDRESS <u>Jewell Hairbank, St. Michaels, Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a) aortic insufficiency producing acute dilatation

30 min.

Antecedent cause(s)  
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last(b) aortic insufficiency with atherosclerotic

at least 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>neither</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>St. Michaels</u>	(COUNTY) <u>Talbot</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from May 25 1951, to May 25 1951, that I last saw the deceased alive on May 25 1951, and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

S. Denning Willson, M.D.May 26 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 28 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>	LOCATION (City, town, or county) <u>St. Michaels</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>May 27 1951</u>	REGISTRAR'S SIGNATURE <u>Mrs. Robert K. Seehn</u>	24. FUNERAL DIRECTOR <u>Newnam &amp; Harrison, St. Michaels Md.</u>		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
MAY 29 1951  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05185

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u></u>	
3. NAME OF DECEASED (Type or Print) <u>Refugio</u> (First) <u>Gilbert</u> (Middle) <u>Gilbert</u> (Last)		4. DATE OF DEATH <u>May 26</u> (Month) <u>26</u> (Day) <u>1951</u> (Year)	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Oct 6, 1886</u>
9. AGE last birthday <u>64</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>James H. Gilbert, Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>and</u>	11. BIRTHPLACE (State or foreign country) <u>and</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Nudley Gilbert</u>	
14. MOTHER'S MAIDEN NAME <u>Annie Cornish</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT AND ADDRESS <u>Mattie Gilbert (Avenue Md)</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

uremia

## Antecedent cause(s)

(b)

Benign Prostatic Hypertrophy

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Fracture spine

## 19a. DATE OF OPERATION

4/18/51

## 19b. MAJOR FINDINGS OF OPERATION

B.P.N.

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT, SUICIDE, HOMICIDE (Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4-9, 1951, to 5/26, 1951, that I last saw the deceasedalive on May 26, 1951, and that death occurred at 1:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/27/51N.H. NewellBeavis H. Bayne820105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED  
JUN 7 1951  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05186

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Queen Anne</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Dallis</u>	(Middle)	(Last) <u>Green</u>
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>31</u>	(Year) <u>1951</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>Black</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>May 4, 1864</u> yrs. <u>87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>James Green</u>	14. MOTHER'S MAIDEN NAME <u>Jillie Small</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT AND ADDRESS <u>Anna Green daughter</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Arteriosclerosis, generalized</u>	
Antecedent cause(s)		(b) <u>450.0</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>51b</u>	
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of Prostate</u>			
19a. DATE OF OPERATION <u>5/21/51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of prostate</u>		20. AUTOPSY? <u>?</u>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/16/51</u> , 19 <u>51</u> , to <u>5/31/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 31</u> , 19 <u>51</u> , and that death occurred at <u>8:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>M. Cox</u>		ADDRESS <u>24-D. Easton Md</u>	DATE SIGNED <u>5/31/51</u>
23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>June 2-51</u>	NAME OF CEMETERY OR CREMATORY <u>Burialtown</u>	LOCATION (City, town, or county) (State) <u>Paulsboro Md</u>
DATE REC'D BY LOCAL REG. <u>5/1/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Neireu</u>	24. FUNERAL DIRECTOR <u>Barton Ben Centerville Md</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

820105

RECEIVED  
JUN 7 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05187

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>107 E. Brooklett Ave.</u>		STREET ADDRESS (If rural, give location) <u>107 E. Brooklett Ave.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Frank</u> (Middle) <u>Bernhardt</u> (Last) <u>Gunther</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>9</u> (Year) <u>1951</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 21, 1869</u>
9. AGE last birthday <u>82</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Rockport, Indiana</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware merchant</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Gunther</u>		14. MOTHER'S MAIDEN NAME <u>Regina Mann (MANN)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Frank Gunther, Easton, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331.X Immediate cause (a) <u>Cerebral Vascular Accident</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
83a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last	
(b) <u>Cerebral Arteriosclerosis</u>	<u>20 years</u>
(c) <u>Right Hemiplegia due to cerebral hemorrhage</u>	<u>19 years</u>

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19...., that I last saw the deceased

alive on ....., 19...., and that death occurred at ..... 10 p.m., from the causes and on the date stated above.

SIGNATURE Shepard Kieckhefer M.D. ADDRESS Easton, Md. DATE SIGNED 5/9/51

23. BURIAL/CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>May 11, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Silver Hill Cemetery</u>	LOCATION (City, town, or county) (State) <u>Easton, Md. 290686</u>
DATE REC'D BY LOCAL REG. <u>5/10/51</u>	REGISTRAR'S SIGNATURE <u>N. H. Navius</u>	24. FUNERAL DIRECTOR <u>John D. Williams</u>	ADDRESS <u>Easton, Md.</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05188

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH - COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Queen Anne's</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (First) <u>HOWARD</u> (Middle) <u>PAVNE</u> (Last) <u>INGLES</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>29</u> (Year) <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 21, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Investment Banker</u>	
11. BIRTHPLACE (State or foreign country) <u>Lexington, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr. Gray S. Ingles</u>		14. MOTHER'S MAIDEN NAME <u>Jeanne M. O'Sullivan</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Miss Virginia Dudley</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

Subarachnoid Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

5/28/57

## Antecedent cause(s)

(b)

arteriosclerosis, generalized

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

5/28/57

## 19b. MAJOR FINDINGS OF OPERATION

Spinal tap showed bloody spinal fluid

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT

(Specify)

SUICIDE

PLACE (Home, farm, factory, street, OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF INJURY

INJURY OCCURRED

While at

Work ☐ Not WhiteAt work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28/57, 1957, to 5/29/57, 1957, that I last saw the deceasedalive on 5/29/57, 1957, and that death occurred at 6:45 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION

REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/30/57N.H. NevinsPeter BrosCenterville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

05189

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>		STREET ADDRESS (If rural, give location) <u>Vine St</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Viola</u> (Middle) <u>Elizabeth</u> (Last) <u>Jackson</u>		(Month) <u>5</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>July 26, 1948</u>
9. AGE last birthday <u>3</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>child</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Easton Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Julius Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mabel Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT <u>Mabel M. Baker, Easton Md</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Fractured skull

INTERVAL BETWEEN ONSET AND DEATH

1/2 hr.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b)

Struck by falling basketball pylon

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Play</u>		(CITY OR TOWN) <u>Easton</u> (COUNTY) <u>Tal.</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5</u> <u>8</u> <u>51</u> <u>3:15 PM</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>see above</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>5/10/51</u>		NAME OF CEMETERY OR CREMATORY <u>Trappe Md</u>		LOCATION (City, town, or county) <u>Trappe Md</u>		(State) <u>Md</u>	
DATE REC'D BY LOCAL REG <u>9/51</u>		REGISTRAR'S SIGNATURE <u>M. A. Neuman</u>		24. FUNERAL DIRECTOR <u>M. E. Neuman</u>		ADDRESS <u>Easton Md</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 15 1951  
BUREAU A. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05190 290  
Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>TALBOT</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>EASTON</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>605 HOOVER ROAD</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>TALBOT</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> TOWN STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Ella</u>	(Middle)	(Last) <u>Johnson</u>
6. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 1, 1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	9. AGE last birthday <u>77</u> yrs.	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Wesley Warner</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Florence Sherwood</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Acute Myocarditis</u>	<u>6. mo</u>
4500 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Arteriosclerosis</u>	<u>2 Years</u>
93a	(c) <u>Acute parenchymatous</u>	<u>4-5 mo</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/6, 1946, to 5/6, 1951, that I last saw the deceased alive on 5/6, 1951, and that death occurred at 10 A.M., from the causes and on the date stated above.

SIGNATURE Hayward T. Webb, M.D. ADDRESS Easton, Md. DATE SIGNED (RR)

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>5/9/51</u>	<u>NEW CHAPEL</u>	<u>EASTON</u>	<u>MD.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/7/51</u>	<u>M. H. Neerius</u>	<u>M. E. NEWNAM &amp; SON</u>	<u>EASTON, MD.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 19 1961  
BUREAU A. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05191  
Reg. Dist. No. .... 290 .....

1. PLACE OF DEATH- COUNTY <i>Talbot</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Chief born in hospital</i> COUNTY <i>STANBURY</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Easton</i>		LENGTH OF STAY (in this place) <i>18 hrs.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <i>STANBURY</i> TOWN <i>Chief had no</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Memorial Hospital</i>				STREET ADDRESS <i>Repealed</i> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <i>Margaret Baybutt Jones</i>		(First) <i>Vigla</i> (Middle) (Last)		4. DATE OF DEATH <i>May 5 1951</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>May 4 1951</i>	9. AGE last birthday If under 1 year Months Days Hours Mln. <i>18</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Mem. Hosp. Easton Md</i>	
13. FATHER'S NAME <i>John Elmer Jones</i>		12. CITIZEN OF WHAT COUNTRY?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <i>Mother - Dawsonville, Md.</i>	
14. MOTHER'S M maiden NAME <i>Lucille Harriet Bennett</i>					

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

760.5 Immediate cause (a) *Respiratory Failure* *Cerebral Hemorrhage*  
160a Antecedent cause(s) (b) *Premature (6 mo) Breach*  
Diseases or conditions, if any,  
giving rise to the above cause  
stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not  
related to the disease or condition causing death.

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from *5-4*, 19*51*, to *5-5*, 19*51*, that I last saw the deceased  
alive on *May 5*, 19*51*, and that death occurred at *12:20 P.* m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Buried</i>		<i>May 5-51</i>		<i>Dawsonville</i>		<i>Stanbury Md.</i>	
DATE REC'D BY LOCAL REG. <i>5/5/51</i>		REGISTRAR'S SIGNATURE <i>J. H. Neerue</i>		24. FUNERAL DIRECTOR <i>Barton B. Centerville Md</i>		ADDRESS	

205041 224261

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED

MAY 10 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05192

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Harlowe</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>hospital</u> OR TOWN <u>Preston Md</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (First) <u>Ann</u> (Middle) <u>marie</u> (Last) <u>Kujawa</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>May 7, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday If under 1 year Months <u>29</u> Days <u>30</u> If under 24 hrs. Hours <u>50</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Md. Href. Easton Md</u>		12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Kujawa</u>		14. MOTHER'S MAIDEN NAME <u>Anna Marie Williamson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>mother - Preston, Md.</u>			

### 18. MEDICAL CERTIFICATION

#### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Respiratory Failure

Antecedent cause(s)

(b) Prematurity (1# 6oz)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

#### II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

#### 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

#### 20. AUTOPSY?

Yes ☐ No ☒ (STATE)

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 7, 1951, to May 8, 1951, that I last saw the deceased

alive on May 8, 1951, and that death occurred at 4:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/9/51</u>	NAME OF CEMETERY OR CREMATORY <u>Federalburg Cemetery</u>	LOCATION (City, town, or county) <u>Federalburg, Maryland</u>	(State)
DATE REC'D BY LOCAL REG. <u>5/8/51</u>	REGISTRAR'S SIGNATURE <u>N.A. Neerues</u>	24. FUNERAL DIRECTOR <u>J.J. Frampton and Son</u>	ADDRESS	

205 011 272260

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and definitely.

RECEIVED BY THE DIRECTOR OF INVESTIGATION

U. S. DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

RECEIVED  
MAY 18 1961  
BUREAU A. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
TOWN <u>Easton</u>		TOWN <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Harrison Street</u>		STREET ADDRESS (If rural, give location) <u>HARRISON STREET</u>	
3. NAME OF DECEASED (Type or Print) <u>WALTER</u> (First) <u>H.</u> (Middle) <u>LANE</u> (Last)		4. DATE OF DEATH <u>MAY 5, 1951</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>JUNE 20, 1886</u>
9. AGE last birthday <u>64</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own shop</u>	9. AGE last birthday <u>64</u> yrs. <u>10</u> Months <u>16</u> Days
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles M. Lane</u>		14. MOTHER'S MAIDEN NAME <u>Annabel Espey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Mrs. Charles R. Lane</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary occlusion (second attack)</u>	<u>2 wks</u>
Antecedent cause(s) (b) <u>Hypertensive Cardiovascular disease</u>	<u>5 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>May</u> , 19 <u>49</u> , to <u>May</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>May 4</u> , 19 <u>51</u> , and that death occurred at <u>7 A.M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>William S. Seymour</u> (Degree or title)	ADDRESS <u>Easton, Md</u> DATE SIGNED <u>5/7/51</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/7/51</u>
NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton, Md</u> (State)
DATE REC'D BY LOCAL REG. <u>5/6/51</u>	REGISTRAR'S SIGNATURE <u>N.B. Neeris</u>
24. FUNERAL DIRECTOR <u>Maurice E. Newman &amp; Son</u>	ADDRESS <u>Easton, Md 501817</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
MAY 18 1961  
BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

05194

1. PLACE OF DEATH- COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Easton, Md.</u>		LENGTH OF STAY (in this place) <u>17 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Federalburg, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Memorial Hosp.</u>				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Grace</u> (First) <u>Marie</u> (Middle) <u>Lewis</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>25</u> (Day) <u>1951</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 20, 1886</u>	9. AGE last birthday <u>64</u> yrs.	10. under 1 year <u>Months</u> <u>Days</u> <u>Hours</u> <u>Mins.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>hosp</u>		11. BIRTHPLACE (State or foreign country) <u>New York (Sydney)</u>	
12. FATHER'S NAME <u>Mr. George Heimlich</u>		13. MOTHER'S MAIDEN NAME <u>Catherine Kessler</u>		14. CITIZENSHIP OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mrs. Mary Glime (Fed. Md)</u>	

### I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Pulmonary embolism

INTERVAL BETWEEN ONSET AND DEATH

sudden

Antecedent cause(s)

(b) Thrombophlebitis - left iliac vein

7 days

(c) Caecum of body of uterus

(31)

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

Calcified aortic valve

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐  
(STATE)

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1951, to 25 May, 1951, that I last saw the deceased

alive on 25 May, 1951, and that death occurred at 12 pm, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION  
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

5/26/51

N.H. Neerius

J.J. Frampton and Son, Federalburg, Md.

720826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

## MARYLAND STATE DEPARTMENT OF HEALTH

05195

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH. COUNTY <u>Talbot Co</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>MD.</u> COUNTY <u>Eastern</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>		STREET ADDRESS (If rural, give location) <u>Federalburg, Md</u>	
3. NAME OF DECEASED (Type or Print) <u>Sarah Elizabeth Moore</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>3</u> (Year) <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	8. DATE OF BIRTH <u>March 3, 1891</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		11. BIRTHPLACE (State or foreign country) <u>Md (Baltimore Co)</u>	
13. FATHER'S NAME <u>Mr. William C. Russell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Wheatley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		17. INFORMANT AND ADDRESS <u>Mrs. Seligman Moore</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

## Immediate cause

(a)

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

## PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 29th, 1957, to 3 May, 1957, that I last saw the deceasedalive on 3 May, 1957, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL CREMATION REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

720826 Md.

RECEIVED

MAY 10 1951

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <b>Talbot</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Talbot</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		LENGTH OF STAY (in this place) <b>21 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Port Street Ext.</b>				STREET ADDRESS (If rural, give location) <b>Port Street Ext.</b>	
3. NAME OF DECEASED (Type or Print) <b>Louisa Wentworth Nash</b>		(First) (Middle) (Last)		4. DATE OF DEATH <b>5 - 13 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>married</b>	8. DATE OF BIRTH <b>5-9-1886</b>	9. AGE last birthday <b>65</b> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederickburg, Spotsylvania, Va.</b>	
13. FATHER'S NAME <b>James Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Lewis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT AND ADDRESS <b>Mr. Chester A. Nash, Port St. Ext Easton, Md.</b>	

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <b>apoplexy</b>				<b>2 days</b>	
Antecedent cause(s) (b) <b>arteriosclerosis, generalized</b>				<b>3 yrs?</b>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <b>SUICIDE</b>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5-13-61</b> , 19 <b>49</b> , to <b>5-12-61</b> , 19 <b>51</b> ; that I last saw the deceased alive on <b>5-13-61</b> , 19 <b>51</b> ; and that death occurred at <b>1:45</b> p.m., from the causes and on the date stated above.					
SIGNATURE <b>M. Cox</b>		(Degree or title) <b>M.D.</b>		ADDRESS <b>Easton Md.</b> DATE SIGNED <b>5-15-61</b>	
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		DATE THEREOF <b>5-17-61</b>		NAME OF CEMETERY OR CREMATORY <b>Richards Cemetery</b> LOCATION (City, town, or county) (State) <b>Easton, Talbot Co. Md.</b>	
DATE REC'D BY LOCAL REG. <b>5/14/61</b>		REGISTRAR'S SIGNATURE <b>N. H. Neeries</b>		24. FUNERAL DIRECTOR <b>James B. Dashiell, Salisbury, Md.</b> ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

05197

1. PLACE OF DEATH- COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Edston</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Edston</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>P. O. D.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>SUSIE ANNIE PERKINS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>5 5 1951</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>C</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Feb. 19, 1886</u>	
9. AGE last birthday <u>65</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House work</u>		11. BIRTHPLACE (State or foreign country) <u>Edston, Talbot Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>				13. FATHER'S NAME <u>William Samson</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT AND ADDRESS <u>James Perkins</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Chl. Angio-cachexia</u>						<u>6 mo</u>	
Antecedent cause(s) (b) <u>422.2 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>							
(c) <u>Q vitamins</u>						<u>yes</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3-24</u> , 19 <u>51</u> , to <u>5-5</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>5-4</u> , 19 <u>51</u> , and that death occurred at <u>7:00</u> a.m., from the causes and on the date stated above.							
SIGNATURE <u>Dr. F. Buell</u>				ADDRESS <u>Edston</u>		DATE SIGNED <u>5-6-51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>5/8/51</u>		<u>New Chapel</u>		<u>Edston, Talbot Co. Md.</u>			
DATE REC'D BY LOCAL REG. <u>5/6/51</u>		REGISTRAR'S SIGNATURE <u>H. H. Neer</u>		24. FUNERAL DIRECTOR <u>Earl W. Stafford</u>		ADDRESS <u>Edston Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

220826



RECEIVED  
MAY 19 1961  
BUREAU A. R.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05198

Reg. Dist. No. 290

1. PLACE OF DEATH. COUNTY <u>Talbot Co</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u> TOWN <u>Easton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>md.</u> COUNTY <u>Talbot</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mc Daniel, md</u> TOWN <u>Mc Daniel, md</u> STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Charles</u>	(First) <u>Charles</u>	(Middle) <u>Perry</u>	(Last) <u>Perry</u>
4. DATE OF DEATH <u>May 3 1957</u>	(Month) <u>May</u>	(Day) <u>3</u>	(Year) <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>Sept 9, 1906</u>
9. AGE last birthday <u>50</u> yrs.	If under 1 year Months <u>50</u>	If under 24 hrs. Days <u>50</u>	If under 1 year Hours <u>50</u> Min. <u>50</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OR WHAT COUNTRY <u>USA</u>
13. FATHER'S NAME <u>James Perry</u>	14. MOTHER'S MAIDEN NAME <u>Debbie Webb</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <u>1212-03-5305</u>
17. INFORMANT AND ADDRESS <u>James H. Webb</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Arteriosclerotic Heart Disease</u>		<u>2 yrs (?)</u>	
Antecedent cause(s) (b) <u>420.0 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>			
93d (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/18</u> , 19 <u>57</u> , to <u>5-3-</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-3-</u> , 19 <u>57</u> , and that death occurred at <u>8:30 p.m.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>B. Cox</u>		ADDRESS <u>Easton md</u>	
DATE SIGNED <u>5-5-57</u>			
23. BURIAL, CREMATION REMOVAL, (Specify) <u>Burial</u>		DATE THEREOF <u>May 5-1957</u>	
NAME OF CEMETERY OR CREMATORY <u>Colored Cemetery</u>		LOCATION (City, town, or county) <u>Clairborne md</u>	
DATE REC'D BY LOCAL REG. <u>5/4/57</u>		REGISTRAR'S SIGNATURE <u>N.A. Neerue</u>	
FUNERAL DIRECTOR <u>Yvonne &amp; Harrison, St. Michaels</u>		ADDRESS <u>683568 md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 10 1951

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH - COUNTY <u>Talbot</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		LENGTH OF STAY (in this place) <u>24 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>312 Goldsborough St.</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Maria</u> (Middle) <u>Elizabeth</u> (Last) <u>Pruce</u>		4. DATE OF DEATH (Month) <u>May</u> (Day) <u>19</u> (Year) <u>1951</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 2, 1876</u>	9. AGE last birthday <u>74</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Mr. Samuel Plummer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Flowers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>		17. INFORMANT AND ADDRESS <u>Mr. Albert Puce</u>	

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Cerebral Vascular Accident

INTERVAL BETWEEN ONSET AND DEATH

10 days

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Cerebral Arteriosclerosisyrs.(c) Arteriosclerotic Heart Diseaseyrs.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Acute Cholecystitis3 wks.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from....., 19....., to..... 5/19, 1951, that I last saw the deceased

alive on..... 5/19, 1951, and that death occurred at..... 11:23 a.m., from the causes and on the date stated above.

SIGNATURE Shepard Krech Jr. (Degree or title) M.D. ADDRESS Easton DATE SIGNED 5/22/51

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/21/51</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	LOCATION (City, town, or county) <u>Easton</u>	(State) <u>md</u>
DATE REC'D BY LOCAL REG. <u>5/20/51</u>	REGISTRAR'S SIGNATURE <u>N.H. Hedrick</u>	24. FUNERAL DIRECTOR <u>J.P. Williams</u>		ADDRESS <u>Easton md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 29 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

05200

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Va.</u> COUNTY <u>Accomack</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Keller</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hospital</u>				STREET ADDRESS (If rural, give location) <u>✓</u>			
3. NAME OF DECEASED (Type or Print)		(First) <u>JAMES</u>		(Middle)		(Last) <u>Rogers</u>	
4. DATE OF DEATH		(Month) <u>MAY</u>		(Day) <u>25</u>		(Year) <u>1951</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>12/25/1901</u>	
9. AGE last birthday <u>49</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Cutter</u>		11. BIRTHPLACE (State or foreign country) <u>Norfolk Va</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Birrell Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Abanda (unknown)</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>	
16. SOCIAL SECURITY NO. <u>✓</u>		17. INFORMANT <u>Maggie W. Rogers, Keller Va</u>		18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
Immediate cause (a) <u>Fractured skull</u> Antecedent cause(s) (b) <u>Struck by falling tree</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>✓</u>				1 hr +			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				PLACE (Home, farm, factory, street, office bldg., etc.) <u>sawmill in Talbot County</u>			
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5 25 51 3P</u> m.				INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>			
				HOW DID INJURY OCCUR? <u>Struck by falling tree</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .							
SIGNATURE (Degree or title) <u>Louis Whitey MD</u>				ADDRESS <u>Easton Md</u>			
DATE SIGNED <u>5-26-51</u>							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>5/28/51</u>		NAME OF CEMETERY OR CREMATORY <u>Burton's</u>		LOCATION (City, town, or county) (State) <u>Melfa Va.</u>	
DATE REC'D BY LOCAL REG. <u>5/25/51</u>		REGISTRAR'S SIGNATURE <u>N.H. Newnes</u>		24. FUNERAL DIRECTOR <u>J.J. Trampton, Jr</u>		ADDRESS <u>Federalburg Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

950306

RECEIVED  
JUN 4 1951  
BUREAU V. S.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05201

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Tacket</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Tacket</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Rural Eastern</u>		LENGTH OF STAY (in this place) <u>none</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS <u>Rural Eastern Md.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH
<u>Susan</u>		<u>Hunter</u>	<u>Saltzman</u>	<u>May</u>	(Month) (Day) (Year) <u>12</u> <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH <u>May 28, 1860</u>	9. AGE last birthday <u>90</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housework</u>		11. BIRTHPLACE (State or foreign country) <u>Brooklyn, Kings Co. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>David Harrison Hunter</u>		14. MOTHER'S MAIDEN NAME <u>Sophie Forest Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Mr. A. J. Gregory, Jr.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cerebral Thrombosis</u>	<u>3 days</u>
332X Antecedent cause(s)	(b) <u>Cerebral arteriosclerosis</u>	
83B Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Not While Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Apr, 1946, to 12 May, 1951, that I last saw the deceased alive on 12 May, 1951, and that death occurred at 6:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>May 14, 1951</u>	<u>Brookwood Cemetery</u>	<u>Brooklyn</u>	<u>N.Y.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>5/14/51</u>	<u>H. H. Neerue</u>	<u>Willie Cook</u>	<u>Eastern Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

720826

RECEIVED  
MAY 18 1958  
BUREAU A. B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

05202

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH- COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TRAPPE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>Rembert</u> (Middle) <u>Simpson</u> (Last)		4. DATE OF DEATH (Month) <u>MAY</u> (Day) <u>13</u> (Year) <u>1951</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Nov. 30, 1883</u>
9. AGE last birthday <u>67</u> yrs. <u>5</u> Months <u>13</u> Days		10. BIRTHPLACE (State or foreign country) <u>Talbot Co., Md.</u>	
11. USUAL OCCUPATION (Give kind of work and during most of working life, even if retired) <u>STORE KEEPER</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William T. Simpson</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy TERESA LEONARD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT AND ADDRESS <u>Mrs. W. REMBERT Simpson-Trappe, Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

## Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## INTERVAL BETWEEN ONSET AND DEATH

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

## 20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 20<sup>th</sup>, 1950, to May, 1951, that I last saw the deceasedalive on May 13<sup>th</sup>, 1951, and that death occurred at 9:45 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EASTON, Md.

290699

RECEIVED  
MAY 29 1951  
BUREAU A. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

05203

1. PLACE OF DEATH- COUNTY <u>Talbot Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sherrwood md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Mrs Eva</u>	(Middle) <u>Wells</u>	(Last)
4. DATE OF DEATH	(Month) <u>May</u>	(Day) <u>31</u>	(Year) <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Feb 14, 1882</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>69</u> yrs. <u>6</u> months <u>31</u> days <u>1</u> hour <u>0</u> min.
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr Levi F Harrison</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. NEAREST AND ADDRESS <u>Mr Percy W. Harrison</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>metastatic carcinoma primary site</u>			
Antecedent cause(s) (b) <u>unknown</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/25</u> , 19 <u>57</u> , to <u>5/31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/31</u> , 19 <u>57</u> , and that death occurred at <u>8:45 pm</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Dr. J. Harrison</u>		ADDRESS <u>Easton md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>6/2/57</u>	NAME OF CEMETERY OR CREMATORY <u>Sherrwood</u>	LOCATION (City, town, or county) (State) <u>Talbot md</u>
DATE REC'D BY LOCAL REG. <u>6/1/57</u>	REGISTRAR'S SIGNATURE <u>N.H. Neuman</u>	24. FUNERAL DIRECTOR <u>Sherrwood</u>	ADDRESS <u>Easton md.</u>

290826

RECEIVED  
JUN 12 1951  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH COUNTY <u>Talbot Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md.</u> COUNTY <u>Caroline Co.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Easton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Easton Memorial Hosp</u>		STREET ADDRESS (If rural, give location) <u>✓</u>	
3. NAME OF DECEASED (Type or Print) <u>Mrs. Mary Wyatt</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>May 31</u>	(Year) <u>1957</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Nov 22, 1883</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>St. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>St. W.</u>	9. AGE last birthday <u>67</u> yrs. <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mr William Mone</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>Unborn</u>	
17. INFORMANT AND ADDRESS <u>Mr Oscar Wyatt (Greensboro)</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Apoplexy</u>			<u>5-11-51</u>
Antecedent cause(s) (b) <u>Arteriosclerosis generalis</u>			<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Diabetes mellitus</u>			<u>?</u>

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 5/1/57, 1957, to 5/31/57, 1957, that I last saw the deceased alive on 5-31-57, 1957 and that death occurred at 7:45 P.M., from the causes and on the date stated above.

SIGNATURE R. Cox ADDRESS 3m-D. Easton md DATE SIGNED 6/2/57

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/3/57</u>	NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	LOCATION (City, town, or county) (State) <u>Greensboro md.</u>
DATE REC'D BY LOCAL REG. <u>6/1/57</u>	REGISTRAR'S SIGNATURE <u>N. J. Harris</u>	24. FUNERAL DIRECTOR <u>R. B. Rawlings</u>	ADDRESS <u>Greensboro md.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

JUN 7 1951

RECEIVED